I URGE STATE HEALTH DEPARTMENTS, STATE ECONOMIC DEVELOPMENT BOARDS, CONCERNED STATE AND FEDERAL AGENCIES, STATE PRIMARY CARE ORGANIZATIONS AND THE PRIVATE SECTOR TO COME TOGETHER AND SUPPORT THE DEVELOPMENT OF A SYSTEM OF AGRICULTURAL LABOR WE CAN BE PROUD OF; " HEALTHY HARVESTERS ".

AS A PEDIATRIC SURGEON, CARE OF CHILDREN HAS BEEN ~~MOST OF~~ PROFESSIONAL MY CAREER.

I WORRY ABOUT THEM AT ALL LEVELS AND AM ESPECIALLY CONCERNED ABOUT THE FIVE MILLION WHO LIVE IN POVERTY.

I HAVE A CONCERN THAT WE MAKE OUR SYSTEM WORK IN SUCH A WAY THAT CHILDREN RECEIVE THEIR BASIC NEEDS IN THEIR OWN COMMUNITY, BUT WHEN NEEDED, THE KNOWLEDGE AND SYSTEM MUST EXIST TO SEE THAT THOSE WHO NEED IT FIND THEIR WAY TO SPECIALIZED PEDIATRIC CARE.

AND FOR THE PAST SIX YEARS HAVE WORKED TO ESTABLISH THE PRINCIPLE OF COMPREHENSIVE, FAMILY CENTERED, COMMUNITY BASED CARE FOR SPECIAL NEEDS CHILDREN

I AM EQUALLY CONCERNED ABOUT HOW FAMILY PHYSICIANS CAN ACQUIRE THE ~~CONTINUING~~ BURGEONING KNOWLEDGE THEY NEED TO OPERATE IN TODAYS ENVIRONMENT.

I KNOW THIS ANSWER IS NOT JUST OUR LEARNED JOURNALS. I THINK IT IS PROBABLY SOME SORT OF INTERDISCIPLINARY HEALTH EDUCATION PROGRAM RELYING HEAVILY ON AUDIO & VIDEO TECHNOLOGY.

I ENCOURAGE THE AGENCY FOR HEALTH SERVICES RESEARCH AND POLICY TO DO THE NECESSARY RESEARCH TO DEVELOP THE KNOWLEDGE BASE FOR PROGRAMS TO MEET THE SPECIAL INFORMATION AND CONTINUING LEARNING NEEDS OF RURAL FAMILY PHYSICIANS.

THERE IS A GROWING CONCERN ABOUT THE SPREAD OF AIDS AND SUBSTANCE ABUSE IN RURAL AREAS.

DR. JUNE OSBORNE, CHAIR PERSON OF THE NATIONAL AIDS COMMISSION, SHARES THIS CONCERN AND HAS HELD HEARINGS IN RURAL GEORGIA.

I CAN'T PREDICT THE SPREAD OF AIDS IN THE RURAL AREAS, BUT I KNOW WITH CERTAINTY THAT THE FRAGILE RURAL HEALTH CARE SYSTEM HAS ALMOST NO TOLERANCE FOR ADDITIONAL PATIENTS.

HOW MANY CASES OF AIDS WILL IT TAKE TO BANKRUPT A MARGINAL SMALL RURAL HOSPITAL ?

THE ANSWERS LIE IN AIDS AND SUBSTANCE ABUSE PREVENTION EFFORTS, MORE DRUG TREATMENT SLOTS, AND SYSTEMS BUILDING FOR HEALTH AND HUMAN SERVICES LIKE THOSE SPONSORED BY HRSA'S PLANNING GRANTS FOR LOW PREVALENCE HIV STATES AND COMMUNITIES.

I CAN'T LEAVE WITHOUT MENTIONING THE ADDICTIVE AND DEADLY SCOURGE OF TOBACCO.

WE HAVE TURNED THE TIDE, BUT THERE ARE STILL AREAS OF CONCERN: TEENAGE GIRLS IN GENERAL, RURAL MALE ADOLESCENTS AND SMOKELESS PRODUCTS. SMOKING IS ~~[illegible]~~ MORE PREVALENT IN RURAL THAN IN URBAN AMERICA. THE HIGHEST COUNTY RATE OF EMPHYSEMA IS IN WEST. VA.

THE STRUGGLE GOES ON, AS THE CIGARETTE COMPANIES TARGET THE MOST VULNERABLE. THEY HAVE STEPPED UP THEIR ADVERTISING. INSTEAD OF THE 4000 THEY WERE SPENDING EACH MINUTE (2.5 BILLION/YR). THEY ~~[illegible]~~ ARE SPENDING 20% MORE THIS YEAR.

THESE ARE PUBLIC HEALTH ISSUES ALL OF US HAVE TO BELIEVE IN.

STROMER

THERE MUST BE A NEW COMMITMENT TO PUBLIC HEALTH.

THE HEALTH SYSTEM WILL COLLAPSE IF WE DO NOT SUPPORT DISEASE PREVENTION AND HEALTH PROMOTION.

I WOULD LIKE TO SEE A REVITALIZATION OF THE LOCAL HEALTH DEPARTMENT, PERHAPS IN THE KIND OF FLEXIBLE AND COOPERATIVE MODEL I PROPOSED FOR THE NHSC.

THE NEW LEADERSHIP IN HRSA (DR. BOB HARMON) COULD BRING THAT BACK AND REVITALIZE THE MORALE OF FEDERAL EMPLOYEES AS WELL. WE NEED NEW DIRECTION AND POSITIVE PROGRAM ACTION. I HAVENT SEEN OR HEARD OF IT YET.

IN MY VISION FOR THE 1990'S WE MUST ALSO HAVE SYSTEMS OF HEALTH CARE THAT MEET NEEDS WITHIN THE CONSTRAINTS OF EXISTING RESOURCES.

CONCURRENTLY THEIR MUST BE BETTER EDUCATION SYSTEMS, ECONOMIC DEVELOPMENT, AND SUPPORTING INFRASTRUCTURE.

THESE ELEMENTS ARE INTERDEPENDENT AND THEIR LACK CONTRIBUTES TO A CONTINUING CYCLE OF POVERTY. BUT THERE IS HOPE.

KENTUCKY'S RECENT DECISION FOR STATE – WIDE EQUAL FUNDING FOR EDUCATION IS A STEP IN THE RIGHT DIRECTION.

LONG TERM CARE FACILITIES DEVELOPED IN RURAL AREAS MEAN MORE JOBS AND DOLLARS FLOWING TO THE COMMUNITY.

THAT'S ECONOMIC DEVELOPMENT COUPLED WITH HEALTH CARE.

PERHAPS STATES SHOULD GIVE PREFERENCE TO CERTIFICATES OF NEED FOR LONG TERM CARE BEDS IN RURAL AREAS ~~OF~~ AS ONE WAY TO MEET THESE PROBLEMS.

ALSO, OUR MODELS OF CARE MUST START WITH REALISTIC NEEDS ASSESSMENT THAT RECOGNIZES THE UNIQUENESS OF EACH RURAL COMMUNITY.

AND THERE MUST BE A PLANNING PROCESS THAT INVOLVES AND EMPOWERS ALL OF THE COMMUNITY.

SUCH A PLAN MUST MAKE PROVISION FOR AT LEAST THE FOLLOWING:

* MECHANISMS FOR COORDINATION BETWEEN HEALTH AND SOCIAL SERVICES INSTITUTIONS.
* TRAINING OF COMMUNITY PEOPLE FOR EXPANDED AND PARAPROFESSIONAL HEALTH ROLES.
* OFF - SITE PHYSICIAN SUPERVISION & GREATER USE OF NURSE PRACTITIONERS, PHYSICIANS ASSISTANTS, MID - LEVEL MENTAL HEALTH WORKERS, MULTI - COMPETENT TECHNICIANS
* GREATER USE OF LOW COST TECHNOLOGY (E.G. FAX MACHINES, P.C.'S)
* REGIONAL AND STATE - WIDE SYSTEMS OF COMMUNICATION, REFERRAL, AND CARE.

MY TELEVISION STOOPING [illegible]
THE BASIC HEALTH CARE PROBLEMS ARE NOT MUCH DIFFERENT IN URBAN GHETTOS THAN IN RURAL AMERICA.

WE'VE ALWAYS SAID WE NEVER WANTED EVEN A <u>TWO</u>-TIER SYSTEM.

OF HEALTH CARE IN AMERICA.

BUT WE HAVE IT ... AND A <u>THIRD</u> TIER, ALSO.

IN THE FIRST TIER ... THE BOTTOM TIER ... ARE UPWARDS OF PERHAPS 30 MILLION AMERICANS -- ABOUT 13 PERCENT OF THE POPULATION -- WHO FALL THROUGH THE CRACKS AND HAVE NO HEALTH INSURANCE COVERAGE ... NO HIGH OPTIONS ... NO LOW OPTIONS ... NO OPTIONS AT ALL.

THEY'RE NOT OLD ENOUGH FOR MEDICARE AND NOT POOR ENOUGH FOR MEDICAID.

RECENTLY RELEASED FIGURES INDICATE THAT ONE OUT OF EVERY EIGHT AMERICANS FALLS INTO THIS CATEGORY OF THE UNINSURED. FOR BLACKS, THE FIGURES ARE WORSE, WITH ONE OUT OF FIVE BLACKS UNINSURED. AND IN THE HISPANIC POPULATION, ONE OUT OF EVERY FOUR PERSONS HAS NO HEALTH INSURANCE

WHAT, THEN, DOES THIS "HEALTH CARE SYSTEM" OF OURS DO FOR THE UNINSURED?

AS YOU KNOW, IN THE VAST MAJORITY OF CASES THE ANSWER IS ... VERY LITTLE ... OR NOTHING. AND THEY ARE SUFFERING THE CONSEQUENCES.

STUDY AFTER STUDY INDICATES THE CORRELATION BETWEEN NO MEDICAL INSURANCE AND INCREASING HEALTH PROBLEMS.

THE HEALTH PROBLEMS OF THE LOWEST TIER, IF IGNORED BY SOCIETY NOW, WILL BE BORNE BY SOCIETY LATER.

THEN WE HAVE A SECOND TIER.

THIS TIER RECEIVES A NARROW RANGE OF BASIC MEDICAL AND HEALTH SERVICES WITH MORE OR LESS FIXED LEVELS OF REIMBURSEMENT.

THIS IS LOW-OPTION COVERAGE ... MEDICARE AND MEDICAID COVERAGE ... WITH THE PATIENT PAYING MANY COSTS OUT-OF-POCKET OR WITH THE HELP OF SOME FORM OF SUPPLEMENTAL INSURANCE, WHICH IS -- IN MY BOOK -- JUST ANOTHER KIND OF OUT-OF-POCKET EXPENSE.

FINALLY, WE HAVE THE THIRD TIER, THE TOP TIER.

THE PEOPLE IN THIS TIER RECEIVE A FULL RANGE OF MEDICAL AND HEALTH SERVICES. THEY ARE COVERED BY HIGH-OPTION HEALTH INSURANCE AND ALSO HAVE A FEW DOLLARS LEFT OVER TO PAY THE 15 OR 20 PERCENT DIFFERENCE BETWEEN THE ACTUAL BILL FROM THE DOCTOR AND THE CHECK FROM THE INSURANCE COMPANY.

FOR THOSE WITHOUT ACCESS, THE GOAL IS UNIVERSAL COVERAGE TO BE ACHIEVED THROUGH COMPREHENSIVE REFORMS OF GOVERNMENT PROGRAMS FOR THE POOR AND UNINSURED COMBINED WITH RISK POOLING.

MEANWHILE INTERIM STEPS INCLUDE MEDICAID EXPANSION, UNDER EXISTING LAW, AND TAX INCENTIVES TO ENCOURAGE SMALL BUSINESS INSURANCE COVERAGE. ~~THESE LATTER ELEMENTS ARE THE ONLY ONES THAT REQUIRE PUBLIC POLICY REFORMS.~~ WE NEED SOME INNOVATIVE REFORMS ESPECIALLY DESIGNED FOR RURAL AMERICA

THE TIME IS RIGHT FOR CHANGE AND THE ELEMENTS EXIST:

– A MATURING RURAL HEALTH MOVEMENT

– A HEIGHTENED CONGRESSIONAL INTEREST

– STRENGTHENED STATE HEALTH DEPARTMENTS

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- STABLE COMMUNITY AND MIGRANT HEALTH CENTERS

- GROWING NUMBERS OF STATE OFFICES OF PRIMARY CARE

-COMMUNITY MOBILIZATION AROUND POTENTIAL RURAL HOSPITAL CLOSINGS

THE TIME IS NOW AND YOU HOLD THE KEYS •

IN CLOSING, I PLAN TO SPEND THE CURRENT PHASE OF MY CAREER MAKING AMERICA AWARE OF ITS HEALTH PROBLEMS SUGGESTING APPROACHES TO CONFRONTING THEM, AND GOADING THE COUNTRY TO ACTION. YOUR GOALS ARE SIMILAR.

I WILL NEVER BE A "COUNTRY BOY", BUT I WILL SUPPORT THE EFFORTS OF MY "COUNTRY COUSINS"S IN THE NRHA AND BE PROUD TO BE THEIR FRIEND.